FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **MT**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Signature:

Jacqueline G. Forba

SCHIP Program Name(s): **Montana**

SCHIP Program Type:

- ☐ SCHIP Medicaid Expansion Only
- ☒ Separate Child Health Program Only
- ☐ Combination of the above

Reporting Period: **2003** *Note: Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02.*

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Submission Date: **12/31/03**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to comment why, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility						From	0	% of FPL for **conception to birth**	0	% of FPL
	From		% of FPL for **infants**		% of FPL	From	0	% of FPL for **infants**	150	% of FPL
	From		% of FPL for children ages **1 through 5**		% of FPL	From	0	% of FPL for children ages **1 through 5**	150	% of FPL
	From		% of FPL for children ages **6 through 16**		% of FPL	From	0	% of FPL for children ages **6 through 16**	150	% of FPL
	From		% of FPL for children ages **17 and 18**		% of FPL	From	0	% of FPL for children ages **17 and 18**	150	% of FPL
Is presumptive eligibility provided for children?	☐ No					☒ No				
	☐ Yes, for whom and how long?					☐ Yes, for whom and how long?				
Is retroactive eligibility available?	☐ No					☒ No				
	☐ Yes, for whom and how long?					☐ Yes, for whom and how long?				
Does your State Plan contain authority to implement a waiting list?	Not applicable					☐ No				
						☒ Yes				
Does your program have a mail-in application?	☐ No					☐ No				
	☐ Yes					☒ Yes				
Can an applicant apply for your program over phone?	☐ No					☒ No				
	☐ Yes					☐ Yes				
Does your program have an application on your website that can be printed, completed and mailed in?	☐ No					☐ No				
	☐ Yes					☒ Yes				
Can an applicant apply for your program on-line?	☒ No					☒ No				
	☐ Yes – please check all that apply					☐ Yes – please check all that apply				
	☐ Signature page must be printed and mailed in					☐ Signature page must be printed and mailed in				
	☐ Family documentation must be mailed (i.e., income documentation)					☐ Family documentation must be mailed (i.e., income documentation)				
	☐ Electronic signature is required					☐ Electronic signature is required				
						☐ No Signature is required				

	SCHIP Medicaid Expansion Program	Separate Child Health Program
Does your program require a face-to-face interview during initial application	☐ No ☐ Yes	☒ No ☐ Yes
Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☐ No ☐ Yes Note: this option requires an 1115 waiver Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6 Specify number of months	☐ No ☒ Yes Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6 Specify number of months 3
Does your program provides period of continuous coverage <u>regardless of income changes?</u>	☐ No ☐ Yes Specify number of months Explain circumstances when a child would lose eligibility during the time period in the box below	☐ No ☒ Yes Specify number of months 12 Explain circumstances when a child would lose eligibility during the time period in the box below If a child dies, turns age 19, moves from the state, is enrolled in Medicaid, becomes eligible for Montana state employee health insurance or is found to have other creditable health insurance coverage. Note:12 months eligibility is not necessarily 12 months enrollment, due to time spent on waiting list.
Does your program require premiums or an enrollment fee?	☐ No ☐ Yes Enrollment Fee $ Premium Amount $ Yearly cap $ Briefly explain fee structure in the box below	☒ No ☐ Yes Enrollment Fee $ Premium Amount $ Yearly cap $ Briefly explain fee structure in the box below
Does your program impose copayments or coinsurance?	☐ No ☐ Yes	☐ No ☒ Yes
Does your program require an assets test?	☐ No ☐ Yes If Yes, please describe below	☒ No ☐ Yes If Yes, please describe below
Is a preprinted renewal form sent prior to eligibility expiring?	☐ No Yes, we send out form to family with their information precompleted and ☐ ask for confirmation ☒ Do not require a response unless income or other circumstances have changed	☐ No Yes, we send out form to family with their information precompleted and ☒ ask for confirmation ☐ do not require a response unless income or other circumstances have changed

Enter any Narrative text below.

2. Are the income disregards the same for your Medicaid and SCHIP Programs? ☒ Yes ☐ No

3. Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs? ☒ Yes ☐ No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☐	☐	☒
b) Application	☐	☐	☒	☐
c) Benefit structure	☐	☐	☐	☒
d) Cost sharing structure	☐	☐	☐	☒
e) Cost sharing collection process	☐	☐	☐	☒
f) Crowd out policies	☐	☐	☐	☒
g) Delivery system	☐	☐	☐	☒
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☐	☒	☐
i) Eligibility levels / target population	☐	☐	☐	☒
j) Eligibility redetermination process	☐	☐	☐	☒
k) Enrollment process for health plan selection	☐	☐	☐	☒
l) Family coverage	☐	☐	☐	☒
m) Outreach (add examples, e.g., decrease, funds, target outreach)	☐	☐	☒	☐
n) Premium assistance	☐	☐	☐	☒
o) Prenatal eligibility expansion	☐	☐	☐	☒
p) Waiver populations (funded under title XXI)				
Parents	☐	☐	☐	☒
Pregnant women	☐	☐	☐	☒
Childless adults	☐	☐	☐	☒
q) Other – please specify				
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

5. For each topic you responded yes to above, please explain the change and why the change was made, below.

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	We revised the renewal application for increased clarity.
c) Benefit structure	
d) Cost sharing structure	
e) Cost sharing collection process	
f) Crowd out policies	
g) Delivery system	
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	We discontinued the income documentation requirement. We implemented a Quality Assurance Program that includes audits of a random sample of applications with children recently determined eligible for SCHIP. We made this change to simplify the renewal process for families. We also intend to implement an on-line application in the future.
i) Eligibility levels / target population	
j) Eligibility redetermination process	
k) Enrollment process for health plan selection	
l) Family coverage	
m) Outreach (add examples, e.g., decrease, funds, target outreach)	Due to the large number of children on our waiting list and the wait prior to enrollment, we focused on current SCHIP families. We stressed the importance of understanding and using their children's benefits for medical, eyeglasses and dental services. We also emphasized the importance of reapplying to continue their children's SCHIP coverage.
n) Premium assistance	
o) Prenatal eligibility expansion	
p) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
q) Other – please specify	
a.	
b.	

c.	

SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Specify if the strategic objective listed is new/revised or continuing, the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

(1) Strategic Objectives	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives related to Reducing the Number of Uninsured Children		
Decrease the proportion of Montana children who are uninsured and reduce financial barriers to affordable health care coverage.	Decrease the proportion of children at or below 150% FPL who are uninsured.	New/Revised ☐ Continuing ☒ Data Sources: Curent Population Survey (CPS) Methodology: 1994, 1995, 1996 merged data set (baseline) comparison with FFY 2003 data Progress Summary: By the end of FFY 03 the number of uninsured children decreased by 2,175 due to coverage by CHIP, Medicaid and the Caring Program for Children. Montana is conducting an in-depth analysis, funded by a HRSA State Planning Grant, of the uninsured population to determine an accurate number of the uninsured and to identify the most effective options for providing Montanans with access to affordable health insurance coverage. The information obtained through research, surveys, focus groups, key informant interviews and public meetings will provide state policy makers with greater insight into the reasons why nearly one in five Montanans are uninsured. The results will enable us to more accurately report to CMS the number of uninsured children in our state. The final report is expected in early 2004.
Objectives Related to SCHIP Enrollment		
Enroll eligible Montana children in CHIP	Enroll approximately 9,540 children monthly who are at or below 150% FPL during FFY 2003	New/Revised ☐ Continuing ☒ Data Sources: BCBS enrollment data for SCHIP Methodology: Calculate average monthly enrollment and compare to target for enrollment

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Progress Summary: Because of limited state funding, we were unable to draw down all available federal funds. We enrolled an average of 9,546 children per month and eligible children over that amount were placed on the waiting list. At the end of FFY 03 there were 1,228 children on the waiting list and the estimated wait before enrollment was 6-8 months.
Objectives Related to Increasing Medicaid Enrollment		
Increase the enrollment of currently eligible but not participating children in the Medicaid program	Refer potentially eligible children to county Offices of Public Assistance and follow-up to assure enrollment in Medicaid or CHIP	New/Revised ☐ Continuing ☒ Data Sources: CHIP data system and TEAMS electronic report Methodology: Monitor potentially Medicaid eligible applications referred to OPAs by conducting data file comparisons Progress Summary: The number of applications referred to county OPAs as potentially eligible for Medicaid was 856. This represents approximately 1,712 children. The number of children who were referred as potentially eligible for Medicaid and subsequently enrolled in Medicaid or CHIP is not available.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
Coordinate with other health care programs that provide coverage and services to children to increase access to health care.	Coordinate with Children's Special Health Services (CSHS), the Mental Health Services Plan (MHSP), Caring Progam for Children, Primary Care Association (PCA), Montana Youth Care, Blue CAre, Montana Comprehensive Health Association to ensure that children and families who need care beyond what is offered by CHIP are referred to these programs.	New/Revised ☐ Continuing ☒ Data Sources: CHIP data system Methodology: Calculate the number of referrals to other health care programs Progress Summary: In FFY 2003 there were the following referrals: CSHS - 161 children Caring Program - approximately 3,746 children MHSP - 8 children The reason so few children were referred to MHSP is that only those children who are not eligible for SCHIP or Medicaid are now eligible for MHSP benefits. This change was effective August 2002. In addition, CHIP staff mail information about PCA members (Community Health Centers, National Health Service Corps (NHSC) sites,, Migrant and Indian Health clinics) to families with children on the CHIP waiting list and enrollees who lose CHIP because they become 19 years old. Staff provides information and referrals to Blue Care, Montana Youth Care and the Montana Comprehensive Health Association to callers to our toll-free hotline.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
Improve access to health care for CHIP children in Montana communities.	Increase the number of medical, and dental providers and facilities available to provide care to CHIP enrollees.	New/Revised ☒ Continuing ☐ Data Sources: BCBS and SCHIP data systems

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	enrollees.	Methodology: Compare provider enrollment data from FYE 2003 with FYE 2002
		Progress Summary: Physicians and Allied Providers: 10% increase. There were 3,294 at FYE 2003 compared to 3,002 at FYE 2002. Dental Providers: 5% increase. There were 240 at FYE 2003 compared to 229 at FYE 2002. Facilities: .04% decrease. There were 57 hospitals at FYE 2003 compared to 59 hospitals at FYE 2002.
Other Objectives		
Maintain continuous health coverage for CHIP eligible enrollees	Increase reapplication rate	New/Revised ☐ Continuing ☒
		Data Sources: CHIP data system
		Methodology: Compare the reapplication rates at the beginning and end of FFY 2003
		Progress Summary: The reapplication rate increased from 87% in October 2002 to 89%in September 2003. The reapplication rate for FFY 03 was 88%. This rate is a result of improvements to our renewal materials (postcard, pre-printed application and reminder notice) and quarterly newsletters that stressed the importance of reapplying for continuous CHIP coverage.

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found?

   Each quarter we review the total number of dental, physician and hospital SCHIP providers in the state to evaluate network adequacy and access to care. If there is a significant change we look to assure that the change did not leave any region of the state with an inadequate network of providers. It should be noted tha Montana is a frontier state with many areas with no, or limited, local access to healthcare for any payor.

   Our insuror, Blue Cross Blue Shield (BCBS)of Montana, submits quarterly Health Care Management Reports which summarize costs and utilzation of medical and pharmacy services. We meet monthly with BCBS to discuss program changes, sucesses and challenges. Access to care and quality of care are primary areas of focus.

   SCHIP monitors and evaluates the utilization of eyeglasses and dental services. These services are provided on a fee for services basis and not part of the contract with BCBS.

   We conduct an annual survey of SCHIP families to assess satisfaction, access to health care services and utilization of insurance benefits. Our families are highly satisfied with the program (see attached report). Survey results are analyzed and program changes are made when appropriate.

3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available?

   We will continue the measures listed above. In addition we will continue to send Explanations of Benefits (EOB) for eyeglasses and dental services to enrollees who have claims processed for these services.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

   We did not conduct focused quality studies in FFY 2003.

5. Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

   2003 CHIP Enrollee Survey Results and Analysis (attached)

   This is a summary of an annual survey of families with children enrolled in the Montana CHIP program. The survey assesses patient satisfaction with the CHIP program, CHIP providers, and quality of care. In May 2003, 1,000 surveys were mailed to a random sample of CHIP families. Although families might have more than one child enrolled in CHIP, the random sample was based on selecting no more than one child within the same family or household unit. The survey yielded a high response rate of 43%, 432 completed surveys were received.

   Findings:

   *97% of respondents rated their satisfaction with CHIP as very satisfied. On a scale from zero ("completely unsatisfied") to 10 ("completely satisfied") 97 percent of respondents rated their overall level of satisfaction with the CHIP program at a level of seven or higher. This percentage is the same as the latest survey done in 2002.

   *41% rated their provider as "the best personal provider possible", 86% rated their provider between seven and ten (on a scale of zero "worst personal provider possible" to 10 "best personal provider possible").

   *88% rated their understanding of CHIP as high. On a scale from zero to 10 ("understand completely") 88 percent of respondents rated their overall understanding at a level of seven or higher. In 2002, 81 percent rated their understanding at level seven or higher.

   *32% reported their child received preventive care. This is up three percent from 2002.

   *86% surveyed reported their child had not used the emergency room in the last six-month period. This percent did not change from 2002.

   *92% reported they felt there was never a time when their child received fewer services than other patients.

   *87% surveyed rated their dental care as "best possible". On a scale from zero to 10 ("best dental care possible") 87 percent of respondents rated their overall understanding at a level of seven or higher. This is up six percent from 2002.

   *80% reported using the BlueCHIP enrollee handbook, 99% of those who used the handbook found it very or somewhat useful.

   Survey of Families Who Did Not Renew CHIP Coverage for July 2003 (attached)

   Findings:

   *61% of the families who did not reapply for CHIP for July 2003 were successfully contacted.

   *75% of the families contacted indicated they received the renewal application.

   *30% of families contacted had a change in work status and an additional 25% didn't think they were eligible for CHIP.

   *50 % of the families contacted indicated their child currently had other health insurance or Medicaid.

   *45% of families contacted whose children had other health coverage indicated it was through an employer and 33% had Medicaid.

*78% percent of families contacted wanted to reapply for CHIP.

REPORTING OF NATIONAL PERFORMANCE MEASURES

The Centers for Medicare & Medicaid Services (CMS) convened the Performance Measurement Partnership Project (PMPP) as a collaborative effort between Federal and state officials to develop a national set of performance measures for Medicaid and the State Children's Health Insurance Programs (SCHIP). CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001 and the Medicaid Final Rules of June 14, 2002 on managed care.

The PMPP's stated goal is to create a short list of performance measures relevant to those enrolled in Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of some 19 measures, the PMPP group trimmed the list to the following seven core measures (SCHIP states should report on all applicable measures for covered populations to the extent that data is available):

- Well child visits for children in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Comprehensive diabetes care (hemoglobin A1c tests)
- Children's access to primary care services
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

Work remains to resolve technical issues related to implementing the collection, analysis, and reporting of the measures. If your State currently has data on any of these measures, please report them using the format below. Indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Performance Measure	Describe How It Was Measured	Performance Measures and Progress
Well child visits for children in the first 15 months of life	Using standard HEDIS measures	Data Sources: HEDIS data gathered by BCBS for SCHIP
		Methodology: DPHHS reviews HEDIS data for SCHIP enrollees
		Progress Summary: We are unable to determine progress. The size is too small for a valid measure.
Well child visits in the 3rd, 4th, 5th, and 6th years of life	Using standard HEDIS measures	Data Sources: HEDIS data gathered by BCBS for SCHIP
		Methodology: DPHHS reviews HEDIS data for SCHIP enrollees
		Progress Summary: 30.95% of SCHIP children received one or more visits. This is an increase from 28.94% in the previous year.
Use of appropriate medications for children with asthma	Using standard HEDIS measures	Data Sources: HEDIS data gathered by BCBS for SCHIP
		Methodology: DPHHS reviews HEDIS data for SCHIP enrollees
		Progress Summary: Combined 75.95%
Comprehensive diabetes care (hemoglobin A1c tests)	Using standard HEDIS measures	Data Sources:
		Methodology:
		Progress Summary: Not measured.

Performance Measure	Describe How It Was Measured	Performance Measures and Progress
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)	Using standard HEDIS measures	Data Sources: HEDIS data gathered by BCBS for SCHIP
		Methodology: DPHHS reviews HEDIS data for SCHIP enrollees
		Progress Summary: Well child visits and immunizations: 29.57% Childrens' access to primary care providers: 12-24 months = 94.73% 25 months-6 years = 80.21% 7-11 years = 83.24%
Adult access to preventive/ambulatory health services	Not applicable.	Data Sources:
		Methodology:
		Progress Summary:
Prenatal and postpartum care (prenatal visits)	Not applicable.	Data Sources:
		Methodology:
		Progress Summary:

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

ENROLLMENT

1. Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).

0	SCHIP Medicaid Expansion Program (SEDS form 64.21E)	13,084	Separate Child Health Program (SEDS form 21E)

2. Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.

   Due to state continued budget constraints and actions taken by DPHHS to control spending, enrollment in SCHIP continued to be capped. We provided coverage for 13,084 children in FFY 2003 and 13,875 in FFY 2002. The average number of children enrolled per month was 9,546 in FFY 2003 and 9,400 in FFY 2002.The number of children who continued their coverage in FFY 2003 was higher. Hence, turnover as reflected in the ever enrolled number decreased but the average monthly enrollment actually increased.

   At FYE 2003 the cap on enrollment was 9,550 and the number of children determined eligible but on the waiting list was 1,228.

   As reported by the Caring Program for Children, a public-private partnership administered by Blue Cross Blue Shield of Montana, the program enrollment has been increasing. At the end of FFY 2003 there were 1,230 enrolled and 48 on the waiting list compared to 929 children enrolled in FFY 2002 and 299 on their waiting list.

   As reported by the Children's Special Health Services (funded by Title V Maternal and Child Health block grant) 2,707 children received services from their program in FFY 2003. One Thousand Seven Hundred Forty-two (1,742) children attended a pediatric specialty clinic, 809 children received family support, education and resource information and 156 children received financial assistance for health care services not covered by Medicaid, CHIP or other health insurance.

3. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. ***(States with only a SCHIP Medicaid Expansion Program, please skip to #4)***

   The Medicaid enrollment for Montana children age 18 years and under has been steadily increasing. According to the Medicaid data system, the number of children covered by Medicaid was 60,526 in FFY 2003. The enrollment was 57,861 in FFY 2002.(The FFY 2003 number is not final and may increase due to retroactive eligibility.) This increase is due to a variety of economic factors, in addition to SCHIP activities and enrollment simplification.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?

   Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State's progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes or if the program eligibility levels used to determine the baseline have changed.

   ☒ No, skip to the Outreach subsection, below

   ☐ Yes, please provide your new baseline _____ And continue on to question 5

5. On which source does your State currently base its baseline estimate of uninsured children?

☒ The March supplement to the Current Population Survey (CPS)

☐ A State-specific survey

☐ A statistically adjusted CPS

☐ Another appropriate source

A. What was the justification for adopting a different methodology?

Not applicable

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

Not applicable

C. Had your State not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

Not applicable

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

For most of FFY 2003 we again had a long waiting list of SCHIP-eligible children. The list increased in size through the year until it was approximately an 6-8 month wait prior to enrollment. Due to this situation, we chose to focus on educating our SCHIP families about using their medical insurance, dental and vision benefits. Another focus was working with families whose children were enrolled in SCHIP to reapply for SCHIP in a timely manner. We improved our renewal materials and shared information about this in our quarterly newsletters to SCHIP families.

The SCHIP Community Relations Manager attended several conferences and networked with Montana nurses, medical providers, Women Infants and Children (WIC) staff and Native Americans. We sent a large mailing about SCHIP eligibility and benefits to all Montana childcare providers as well as all Montana food banks. We contacted all Community Health Clinics, Migrant Health Clinics, Urban Indian Clinics and National Health Service Corps Sites and provided outreach materials and "universal applications" for Children's Health Programs. We mailed applications, brochures, posters and promotional items to all the Social Security Offices in Montana.

SCHIP received $609,900 from Governor Judy Martz in early FFY 2004. With these new funds and matching funds from the federal government, we were able to enroll all the eligible children on the waiting list on November 1st.

The SCHIP Outreach Plan for 2004 will be finalized within the next month.

2. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The most effective activity in reaching low-income, uninsured children was the media campaign conducted in August and September 2000. Contracting with community advocates was also effective in "getting the word out" about CHIP and provided families with assistance in completing the application process. However, those contracts were discontinued in December 2001.

Last year, due to the lengthy waiting list, we conducted the outreach activities listed in our response to Question 1 above.

In addition, SCHIP, the Department of Public Health and Human Services (DPHHS) and the Office of Public Instruction (OPI) met every other month. SCHIP works very closely with schools to explore the different avenues of outreach for school children and their parents. We keep the schools informed of the current SCHIP status, i.e. enrollment, waiting list numbers and SCHIP policy changes.

It is difficult to measure the effectiveness of these outreach activities. SCHIP keeps records of the number of applications received each month, broken down into new applications, re-enrolls and applications received from Offices of Public Assistance(OPA). However, since so many factors affect the submission of new SCHIP applications, measuring effectiveness of specific activies has been difficult.

3. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

   Montana is mostly rural so most of our outreach is directed to rural communities. We distribute current SCHIP informational materials and applications through the schools, meet with Montana employers/employees on request, and attend hospital open houses and community health fairs throughout Montana.

   We have continued to visit Montana Native American tribes on a regular basis. This is proving to enhance our relationships with the tribes and has made inroads into educating the different tribes about SCHIP benefits and changes in program policies. Our goal is to see the SCHIP enrollment numbers for Native American children increase in response to our efforts.

   As indicated above, many factors affect the submission of SCHIP applications so that measuring effectiveness of specific activies has been inconclusive.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

All States must complete the following 3 questions

1. Describe how substitution of coverage is monitored and measured.

   The universal application asks if children currently have health insurance or if they've had health insurance in the past three months. Children must be uninsured for three months before being eligible for SCHIP. (Some employment-related exceptions apply.) The Enrollee Handbook and SCHIP materials also notify SCHIP families that their children are not eligible if they have other health insurance coverage.

2. Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP?

   We have no data regarding applicants who drop group health plan coverage to enroll in SCHIP.

3. At the time of application, what percent of applicants are found to have insurance?

   We have no data regarding the percent of applicants who have insurance at the time of application. This data will be available once our new SCHIP data system is implemented in 2004.

States with separate child health programs over 200% of FPL must complete question 4

4. Identify your substitution prevention provisions (waiting periods, etc.).

   Not applicable.

States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.

5. Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

   Not applicable

States with waiting period requirements must complete question 6. (This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)

6. Identify any exceptions to your waiting period requirement.

   The waiting period is waived if the parent or guardian providing the insurance:

   1) died

   2) was fired or laid off

   3) can no longer work due to a disability

   4) has a lapse in insurance coverage due to new employment or

   5) has an employer who does not offer dependent coverage

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

   SCHIP and Medicaid do not have the same redetermination procedures. Medicaid requires documentation of all income received into the household. Effective May 2003 SCHIP accepts self-declaration of income and no longer requires income documentation. A Quality Assurance Program was implemented to audit a random sample of applications with children who were determined eligible.

   Neither SCHIP nor Medicaid applicants are required to attend a face-to-face interview.

   Additionally, SCHIP provides families with a renewal application that is pre-populated with information from their previous application (e.g., names, dates of birth, ID numbers, etc.). To expedite the renewal processing, information from the previous SCHIP application is pre-populated on the renewal application. Families are requested to note any changes to the information, sign, date and return the application to the SCHIP office for eligiblity determination. This renewal application takes less time for the family to complete and takes less time for staff to determine SCHIP eligibility. Medicaid does not pre-populate redetermination applications.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain.

   When a local Office of Public Assistance (OPA) closes or denies Medicaid coverage for a child, a copy of the most recent application, current documentation and the closure notice are forwarded to us for an SCHIP eligibility determination. Applications received from OPAs are given priority when

processing SCHIP applications. Children eligible for SCHIP will be enrolled the first of the subsequent month with no time spent on the waiting list.

During FFY 2003 we worked on the development of an electronic file for Medicaid closures and denials that would be sent to us for determination of SCHIP eligibility. This file would replace the current process of OPAs forwarding paperwork to us. Implementation of the electronic file is expected in early 2004.

When children are determined by SCHIP to be potentially eligible for Medicaid, we forward the application to the county OPA for a determination of Medicaid eligibility. SCHIP runs a computer match against Medicaid information in TEAMS on a weekly basis to follow-up on these referrals. If the child is Medicaid eligible, SCHIP coverage will be denied. If the child is denied Medicaid coverage, the child will be eligible for SCHIP if all other eligiblity criteria are met. Children eligible for SCHIP will be enrolled the first of the subsequent month with no time spent on the waiting list if funds are available.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain

   The delivery systems for SCHIP and Medicaid are not the same, although the providers are often enrolled in both programs' networks. SCHIP contracts with Blue Cross Blue Shield of Montana (BCBSMT) to enroll and provide support for medical and allied providers as well as hospitals. SCHIP contracts with Affiliated Computer Services Inc. (ACS) to enroll and support dental and eyeglasses providers. Medicaid enrolls and supports its medical, allied and dental providers through its contractor, ACS. SCHIP and Medicaid state staff provide support for their respective networks and delivery systems.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? *Check all that apply*.

☐ Follow-up by caseworkers/outreach workers

☒ Renewal reminder notices to all families, *specify how many notices and when notified*
The following schedule of renewal mailings is sent: 1) A postcard is mailed approximately 9 ½ months after eligibility was determined and indicates a renewal application will be sent shortly. 2) A renewal application is mailed 10 months after eligibility was determined. 3) A reminder notice is mailed 11 months after eligibility is determined if the renewal application was not returned.

☒ Targeted mailing to selected populations, *specify population*
Quarterly newsletters (see attached) are sent to current SCHIP enrollees and those on the waiting list.

☐ Information campaigns

☒ Simplification of re-enrollment process, *please describe*
The renewal application is much shorter than the initial application and much of the information is pre-populated from the previous application. SCHIP-eligible children who renew their coverage do not need to go on the waiting list prior to enrollment.

☒ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, *please describe*
See response to #3 below

☐ Other, *please explain*

2. Which of the above measures have been effective? Describe the data source and method used to derive this information.

   Improving the renewal materials and implementing a renewal application that was shorter and easier to complete resulted in an increased number of returned renewal applications, decreased time for application processing and continuous coverage for more SCHIP children.

   The telephone survey was effective because it provided the following:

   1) data pertaining to families who did not reapply for SCHIP,

   2) an opportunity to talk with applicants who had questions or misinformation about their child's eligibilty for SCHIP

   3) feedback to SCHIP about our eligiblity determination and enrollment procedures

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or how many move?) If so, describe the data source and method used to derive this information.

   According to the SCHIP data system, the reasons for disenrollment in FFY 2003 were:

   54.5% Enrolled in Medicaid

   14.4% Became 19 years old

   13.7% Moved out of state

   12.2% Obtained other insurance

   4.1% Other reasons

   .9% Became eligible for state employee health benefits

   .2% Death of the enrolled child

   According to the "Survey of Families Who Did Not Renew CHIP Coverage for July 2003", the reasons given by applicants for not reapplying for SCHIP at the time of renewal were:

   30% Change in work status

   25% Didn't think children would be eligible

   20% Other reasons

   10% Change in personal status

   5% Didn't get paperwork done in time

   5% Didn't receive renewal materials

   5% No reason

   The reported insurance or Medicaid coverage after SCHIP ended was:

   50% Did not have other insurance or Medicaid

   50% Had other insurance or Medicaid

   Of the 50% who said their SCHIP children had other insurance or Medicaid:

   44.4% Obtained employer-based health insurance

   33.3% Enrolled in Medicaid

11.1% Obtained individual health insurance

11.1% Considered Indian Health Service as insurance

Of the all the respondents, 66% indicated they want to reapply and 24% did not want to reapply for SCHIP. (Applications were sent to respondents who wanted to reappply.)

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   Not applicable.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

   During the SCHIP Survey of Families Who Did Not Renew CHIP Coverage for July 2003, families were asked their reasons for not re-applying for SCHIP and cost-sharing was not mentioned as a barrier by respondents.

   During the CHIP Enrollee Survey families gave CHIP high satisfaction ratings and did not report that the cost-sharing (co-payments)affected their child's utilization of health care services. Therefore, we conclude that cost-sharing was not perceived by families as a barrier to enrollment or re-enrollment.

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program using title XXI funds under any of the following authorities?

   Note:

   ☐ Yes, check all that apply and complete each question for each authority.
   - ☐ State
   - ☐ Family Coverage
   - ☐ Section 1115 Demonstration
   - ☐ Health Insurance Accountability & Flexible Demonstration
   - ☐ HIPP

   ☒ No, skip to Section IV.

2. Briefly describe your program (including current status, progress, difficulties, etc.)

3. What benefit package does the program use?

4. Does the program provide wrap-around coverage for benefits? For cost sharing?

5. Identify the total number of children and adults enrolled in the premium assistance program for whom title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever enrolled during the reporting period

_____ Number of children ever enrolled during the reporting period

6. Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program. How was this measured?

7. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

8. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below. *Note: This reporting period = Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02). If you have a combination program you need only submit one budget; programs do not need to be reported separately.*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**Reporting Period**	**Next Fiscal Year**	**Following Fiscal Year**
Insurance payments			
Managed Care			
Per member/Per month rate @ # of eligibles	12,328,382	15,068,486	12,426,158
Fee for Service	1,294,038	1,447,992	1,196,262
Total Benefit Costs	13,622,420	16,516,478	13,622,420
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	13,622,420	16,516,478	13,622,420
Administration Costs			
Personnel	490,664	492,600	492,600
General Administration	358,393	358,300	358,393
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing	109,256	109,200	109,256
Outreach/Marketing costs	7,500	7,500	7,500
Other			
Total Administration Costs	965,813	967,600	967,749
10% Administrative Cap (net benefit costs ÷ 9)	1,513,602	1,835,164	1,513,602
Federal Title XXI Share	11,826,680	14,174,342	11,828,250
State Share	2,761,553	3,309,736	2,761,919
TOTAL COSTS OF APPROVED SCHIP PLAN	14,588,233	17,484,078	14,590,169

PMPM Rate @ # of eligibles

Premium

FFY 2003 $1,291.32 @ 9,547 = $12,328,382

FFY 2004 $1,415.28 @ 10,647 = $15,068,486

FFY 2005 $1,415.28 @ 8,780 = $12,426,158

FFS (Dental + Eyeglasses)

FFY 2003 $135.55 @ 9,547 = $1,294,038

FFY 2004 $136.00 @ 10,647 = $1,447,992

FFY 2005 $136.25 @ 8,780 = $1,196,262

Pre-populated fields for FFY 2004 and 2005 FMAP assume rate for FFY 2003 (81.07) although rates published in Federal Register are 81 for FFY 2004 and 80.33 for FFY 2005.

State Share for FFY 2004 reflect "one-time funding" from Governor.

2. What were the sources of non-Federal funding used for State match during the reporting period?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations (such as United Way, sponsorship)
- ☐ Other (specify)

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What do you estimate is the impact of your State's SCHIP section 1115 demonstration on enrollment, retention, and access to care of children?

4. Please complete the following table to provide budget information. Please describe in narrative any details of your planned use of funds. *Note: This reporting period (Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	Reporting Period	Next Fiscal Year	Following Fiscal Year
Benefit Costs for Demonstration Population #1 (e.g., children)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #1			
Benefit Costs for Demonstration Population #2 (e.g., parents)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #2			
Benefit Costs for Demonstration Population #3 (e.g., pregnant women)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #3			
Total Benefit Costs			
(Offsetting Beneficiary Cost Sharing Payments)			
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)			
Administration Costs			
Personnel			
General Administration			
Contractors/Brokers *(e.g., enrollment contractors)*			
Claims Processing			
Outreach/Marketing costs			
Other *(specify)*			
Total Administration Costs			
10% Administrative Cap (net benefit costs ÷ 9)			
Federal Title XXI Share			
State Share			
TOTAL COSTS OF DEMONSTRATION			

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. Please provide an overview of what happened in your State during the reporting period as it relates to health care for low income, uninsured children and families. Include a description of the political and fiscal environment in which your State operated.

   National and state economic conditions have resulted in a budget shortfall for Montana. Our state legislature convened in January 2003 and their primary focus was addressing Montana's budget deficit and establishing priorities for the next biennium. One of the legislature's biggest challenges was funding health care costs for needy Montanans.

   The increase in the Medicaid caseload for adults and children greatly exceeded the Department's projected enrollment figures. Providing Medicaid coverage for additional Montanans and the increasing cost of health care resulted in much greater program expenditures than anticipated. As a result, funding for other state-supported services was reduced. SCHIP funding was changed from state general funds to Tobacco Settlement funds.

   The rapidly rising cost of health care, especially pharmacy services, has had a significant impact on Montana employers, insurance plans and families.

   The Montana State Planning Grant (SPG) funded by HRSA will provide data about the status of health care for low income, uninsured children and families in these uncertain economic times. The final SPG report is expected in early 2004.

2. During the reporting period, what has been the greatest challenge your program has experienced?

   The greatest challenge was limited state funding for SCHIP. Due to budget constraints, SCHIP enrollment has been limited and SCHIP-eligible children remained uninsured and on our waiting list for 6-8 months prior to enrollment. This created hardship for many uninsured Montana children and their families.

   Expansion of eligibility above 150% of FPL and/or expansion of benefits was unfeasible.

   In addition, contract negotiations with BCBS during FFY 2003 resulted in a substantial increase in the monthly insurance premium for FFY 2004. For these reasons, at the end of FFY 2003 we anticipated having to decrease the number of Montana children SCHIP could insure.

   Fortunately, in October 2003 Montana's governor provided "one-time funding" of $609,900 which will enable us pay the increased premiums for children currently enrolled in SCHIP and allowed us to enroll all the eligible children on our waiting list effective November 1, 2003.

3. During the reporting period, what accomplishments have been achieved in your program?

   Montana's legislature made the following changes to our program:

   1) gave SCHIP the authority to spend private money received from donations, grants and gifts

   2) changed SCHIP funding from the "general fund" to "state special revenue". The state special revenue comes from Montana's Tobacco Settlement and was requested by voters in November 2002 when they passed Iniative 146. This change ensures that state SCHIP funding can not be used to fund other programs.

   3) although there was a bill to exclude 18 year olds from SCHIP, legislators did not pass this and maintained SCHIP eligiblity for 18 year olds.

-Received an outstanding audit report after a Legislative Performance Audit was completed by the Legislative Audit Division. (This report was submitted to CMS with the 2002 SCHIP Annual Report.)

-DPHHS divided our division into two smaller divisions. They are the Public Health Division and the Child and Adult Health Resources Division (CAHR). SCHIP, Medicaid Services, Children's Special Health Services and Children's Mental Health Services are now part of CAHR. This structure will improve communication and coordination of health care services for children.

-Reorganized the staffing structure of SCHIP. Staff were cross-trained and assumed new and more challenging duties. We improved staff satisfaction and communication while at the same time improved our customer service to the public, especially Montanans with uninsured children.

-Partnered with a contractor to redesign the SCHIP data system. This has been a labor-intensive process with delays due to limited funding. A temporary, alternative database was developed to respond to immediate program needs for application tracking, quality assurance, and data analysis.

-Examined and revised program policies and procedures to come into compliance with HIPAA requirements

-Increased utilization of eyeglasses & dental benefits by:

1) educating families about these benefits, how to access them and notified families mid-year of balance remaining for dental services. (SCHIP has a $350 maximum payment for the benefit year.)

2) developing and implementing an Explanation of Benefits (EOB) for eyeglasses and dental services

3) expanding the provider network

-Transitioned to applicant self-declaration of income and implemented an electronic system for Quality Assurance Program audits

-Implemented transitional SCHIP coverage for children losing Medicaid coverage to allow adequate time for SCHIP eligibility determination. This resulted in children having fewer lapses in health care coverage.

-Implemented an electronic system for referrals to the Caring Program for children who were over income for SCHIP

-Improved coordination with Children's Special Health Services as a result of bureau reorganization and co-location of programs

- Developed the SCHIP Resource Manual that provides referral information for families regarding national, state and community health and social services

-Maintained the cost of the monthly insurance premium for FFY 2003.

-Developed and implemented a comprehensive CHIP Policy Manual.

-Increased contact and rapport with Native American tribes in Montana

-Revised our website design, letters to applicants, renewal application, education and outreach materials

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

-We will increase SCHIP enrollment due to funding from the governor that will be matched with federal funds.

-We will work to obtain grants and donations to enable us to maintain SCHIP enrollment after the governor's "one-time funding" has been expended.

-We will implement the SCHIP Administrative Rules which we revised in FFY 03 and early FFY 04.

-We will be reviewing and amending our SCHIP State Plan.

-We will consider increasing the dental payment maximum as a result of comments in the CHIP Enrollee Survey and feedback from dental providers. We will examine the percent of children who have met or exceeded the maximum since the inception of our program.

-We will implement our new SCHIP data system in order to improve our eligiblity and enrollment procedures. This change will also improve our data analysis, program evaluation and management.

-We will replace our current referral process from county OPAs for children whose Medicaid coverage was closed or denied. We will get an electronic file from TEAMS of those denials and closures. This will allow SCHIP to respond in a more timely manner to families whose children lose or are denied Medicaid and decrease the time children may be without health coverage.

-We hope to implement a paperless (electronic) filing system to improve the efficiency of the SCHIP eligibility determination, enrollment and referral processes.